True Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 06/01/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

1 ultrasling
1 right shoulder arthroscopic labral repair and debridement

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

xxxxx is a xx year old male, with complaints of shoulder pain. On xxxxx, an MRI of the right shoulder was obtained, documenting that the rotator cuff was intact and the biceps tendon was intact. There was increased signal within the substance of the posterior superior labrum suggesting a labral tear. The superior labrum at the level of the biceps anchor attachment was intact. There was also abnormal morphology and signal intensity of the anterior-inferior labrum suggestive of a torn degenerated labrum. On 04/27/2015, the patient was seen in clinic and complained of right shoulder pain, stiffness, swelling and popping. He related an injury while moving medical lab equipment with gradual onset of pain, locking, and loss of motion.

On exam, there was a positive apprehension sign for instability of the right shoulder, and the position of abduction in external/internal rotation caused a catching sensation. The MRI was reviewed, and surgery was recommended and discussed.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 04/30/15 a utilization review recommended non certifying the requested right shoulder arthroscopic labral repair and debridement, utilizing ODG shoulder chapter. it was noted that conservative measures had not been exhausted and no comprehensive physical exam had been provided. Thus, the request was non-certified.

on 05/08/15, a UTILIZATION REVIEW RECOMMENDED NON CERTIFYING THE REQUESTED RIGHT SHOULDER ARTHROSCOPIC LABRAL REPAIR AND DEBRIDEMENT, UTILIZING ODG SHOULDER CHAPTER, it was noted there was lack of documentation of at least three months conservative care. The request was recommended for non-certification.

The submitted records include documentation of physical therapy from 03/09/15 through 3/27/15. The records do not conclusively document that this patient has failed at least three months of consecutive

conservative care as recommended by the guidelines.

it is the opinion of this reviewer that the request for one right shoulder arthroscopic labral repair and debridement
is not medically necessary and the prior denials are upheld.

IT IS THE OPINION OF THIS REVIEWER THAT THE REQUEST FOR ONE ULTRA SLING, IS NOT MEDICALLY NECESSARY AND THE PRIOR DENIALS ARE UPHELD.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)